FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 8049116

Facility Name: Harvard Memorial Hospital

Address: 901 S. Grant Street (Number) Harvard (City) 60033 (Zip Code)

County: McHenry

Telephone Number: (608) 755-5362 X5008 **Fax #** (608)-741-7368

IDPA ID Number: 311551871-002

Date of Initial License for Current Owners: 1954

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501C (3)			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Julie Goodman **Telephone Number:** (608)755-5362 X5008

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Dan Colby

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 45

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	45	Skilled (SNF)	45	8,190	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	45	TOTALS	45	8,190	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		4,043	417	4,460	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS		4,043	417	4,460	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 54.46%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels, employee meals

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1976

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date March 2003 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 417

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/2004 Fiscal Year: 6/30/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	110,087	1,403	134,950	246,440	(290)	246,150	(42,320)	203,830			1
2	Food Purchase											2
3	Housekeeping	90,118	13,533	245	103,896		103,896	(83,672)	20,224			3
4	Laundry	6,609	1,088	33,635	41,332		41,332	(20,666)	20,666			4
5	Heat and Other Utilities					113,616	113,616	(91,501)	22,115			5
6	Maintenance	101,785	93	265,613	367,491	(114,818)	252,673	(203,492)	49,181			6
7	Other (specify):* **Central Supply**	19,876	19,791	15,132	54,799	(11,931)	42,868	(7,370)	35,498			7
8	**TOTAL General Services**	328,475	35,908	449,575	813,958	(13,423)	800,535	(449,021)	351,514			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,498,044	518,176	1,012,156	3,028,376	(2,078,359)	950,017	(81,477)	868,540			10
10a	Therapy	222,359	12,256	6,883	241,498		241,498	(41,520)	199,978			10a
11	Activities											11
12	Social Services											12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* **clinical programs**	1,172,425	(73,475)	681,404	1,780,354	(1,780,354)						15
16	**TOTAL Health Care and Programs**	2,892,828	456,957	1,700,443	5,050,228	(3,858,713)	1,191,515	(122,997)	1,068,518			16
	C. General Administration											
17	Administrative	17,765	3,848	105,071	126,684	(11,701)	114,983	(56,186)	58,797			17
18	Directors Fees											18
19	Professional Services					6,038	6,038	(2,950)	3,088			19
20	Dues, Fees, Subscriptions & Promotions					16,369	16,369	(7,999)	8,370			20
21	Clerical & General Office Expenses	150,542	3,643	227,660	381,845	(19,268)	362,577	(177,173)	185,404			21
22	Employee Benefits & Payroll Taxes			923,146	923,146		923,146	(805,537)	117,609			22
23	Inservice Training & Education											23
24	Travel and Seminar					4,637	4,637	(2,266)	2,371			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			308,699	308,699		308,699	(150,846)	157,853			26
27	Other (specify):* **Human resources**	49,666	1,583	31,480	82,729	(3,985)	78,744	(68,712)	10,032			27
28	**TOTAL General Administration**	217,973	9,074	1,596,056	1,823,103	(7,910)	1,815,193	(1,271,669)	543,524			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,439,276	501,939	3,746,074	7,687,289	(3,880,046)	3,807,243	(1,843,687)	1,963,556			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Harvard Memorial Hospital #8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			370,395	370,395		370,395	(365,684)	4,711			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			231,946	231,946		231,946	(231,946)				32
33	Real Estate Taxes					12,503	12,503	(12,503)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles					13,970	13,970	(13,181)	789			35
36	Other (specify):* Bad Debt			612,654	612,654		612,654	(612,654)				36
37	TOTAL Ownership			1,214,995	1,214,995	26,473	1,241,468	(1,235,968)	5,500			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			798	798		798		798			38
39	Ancillary Service Centers					3,841,220	3,841,220	(3,841,220)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					12,353	12,353		12,353			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			798	798	3,853,573	3,854,371	(3,841,220)	13,151			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,439,276	501,939	4,961,867	8,903,082		8,903,082	(6,920,875)	1,982,207			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule see attached page 5A				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology	X		see schedule		42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule	X		see schedule		45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Harvard Memorial Hospital

ID# 8049116

Report Period Beginning: 1/1/2004

Ending: 6/30/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Dietary Expenses not related to SNF care	$ 42,320	1	1
2	Housekeeping Expenses not related to SNF care	83,672	3	2
3	Laundry Expenses not related to SNF care	20,666	4	3
4	Heat and Other Utilities not related to SNF care	91,501	5	4
5	Maintenance Expenses not related to SNF care	203,492	6	5
6	Central Supply Expenses not related to SNF care	7,370	7	6
7	Nursing & Medical Records Expenses not related to SNF	81,477	10	7
8	Therapy Expenses not related to SNF care	41,520	10a	8
9	Administrative Expenses not related to SNF care	56,186	17	9
10	Professional Services not related to SNF care	2,950	19	10
11	Dues, Fees and Subscriptions not related to SNF care	7,999	20	11
12	Clerical & General Office Expenses not related to SNF ca	177,173	21	12
13	Employee Benefits & Payroll Taxes not related to SNF ca	805,537	22	13
14	Travel and Seminar Expenses not related to SNF care	2,266	24	14
15	Insurance Expense not related to SNF care	150,846	26	15
16	Human Resources & Marketing Expense not related to SN	68,712	27	16
17	Depreciation not related to SNF care	365,684	30	17
18	Interest Expense not related to SNF care	231,946	32	18
19	Real Estate taxes not related to SNF care	12,503	33	19
20	Rent Expense - Equipmnt - not related to SNF care	13,181	35	20
21	Ancilliary Services related to Acute not SNF Operations	3,841,220	39	21
22	Bad Debt Expense	612,654	36	22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	6,920,875		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 1/1/2004 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	42,320	0	0	0	0	0	0	0	0	0	0	42,320	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	83,672	0	0	0	0	0	0	0	0	0	0	83,672	3
4	Laundry	20,666	0	0	0	0	0	0	0	0	0	0	20,666	4
5	Heat and Other Utilities	91,501	0	0	0	0	0	0	0	0	0	0	91,501	5
6	Maintenance	203,492	0	0	0	0	0	0	0	0	0	0	203,492	6
7	Other (specify):*	7,370	0	0	0	0	0	0	0	0	0	0	7,370	7
8	**TOTAL General Services**	449,021	0	0	0	0	0	0	0	0	0	0	449,021	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	81,477	0	0	0	0	0	0	0	0	0	0	81,477	10
10a	Therapy	41,520	0	0	0	0	0	0	0	0	0	0	41,520	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	122,997	0	0	0	0	0	0	0	0	0	0	122,997	16
	C. General Administration													
17	Administrative	56,186	0	0	0	0	0	0	0	0	0	0	56,186	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	2,950	0	0	0	0	0	0	0	0	0	0	2,950	19
20	Fees, Subscriptions & Promotions	7,999	0	0	0	0	0	0	0	0	0	0	7,999	20
21	Clerical & General Office Expenses	177,173	0	0	0	0	0	0	0	0	0	0	177,173	21
22	Employee Benefits & Payroll Taxes	805,537	0	0	0	0	0	0	0	0	0	0	805,537	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	2,266	0	0	0	0	0	0	0	0	0	0	2,266	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	150,846	0	0	0	0	0	0	0	0	0	0	150,846	26
27	Other (specify):*	68,712	0	0	0	0	0	0	0	0	0	0	68,712	27
28	**TOTAL General Administration**	1,271,669	0	0	0	0	0	0	0	0	0	0	1,271,669	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	1,843,687	0	0	0	0	0	0	0	0	0	0	1,843,687	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 1/1/2004 **Ending:** 6/30/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	**365,684**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**365,684**	30
31	Amortization of Pre-Op. & Org.	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	31
32	Interest	**231,946**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**231,946**	32
33	Real Estate Taxes	**12,503**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**12,503**	33
34	Rent-Facility & Grounds	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	34
35	Rent-Equipment & Vehicles	**13,181**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**13,181**	35
36	Other (specify):*	**612,654**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**612,654**	36
37	**TOTAL Ownership**	**1,235,968**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,235,968**	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	38
39	Ancillary Service Centers	**3,841,220**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,841,220**	39
40	Barber and Beauty Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	40
41	Coffee and Gift Shops	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	41
42	Provider Participation Fee	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	42
43	Other (specify):*	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	43
44	**TOTAL Special Cost Centers**	**3,841,220**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**3,841,220**	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	**6,920,875**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**6,920,875**	45

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mercy Health System	100 %			Mercy Hospital	Janesville, WI	hospital
				Mercy Assisted Care	Janesville, WI	includes Homecare,
				Mercy Alliance	Janesville, WI	parent corporation,

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V				N/A				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 12/30/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mercy Health System
Street Address: 1000 Mineral Point Ave
City / State / Zip Code: Janesville, WI 53545
Phone Number: (608-755-5362 Ext 5008
Fax Number: (608-741-7368

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Maintenance General Expense	hrs worked	4,160	2	$ 58,713	$ 58,713	900	$ 12,702	1
2	17	Executive Payroll	actual salary	1	1	86,250	86,250	1	86,250	2
3	21	Clerical & Office General Expens	hrs worked	156,936	5	2,468,604	2,468,604	7,470	117,503	3
4	22	Workers Compensation	FTE's	2,367	5	729,681	0	146	44,863	4
5	26	Gen/Prof Liability Insurance	actual expense	1	1	308,699	0	1	308,699	5
6	27	Other (Human Resources) Gener	hrs worked	14,833	5	308,701	308,701	577	12,008	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 3,960,648	$ 2,922,268		$ 582,025	25

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1998 Bond Issue	X		Medical Clinic Construction	$75,000- annual	1998	$ 1,750,000	$ 1,430,000	2016	variable	$ 13,102	1
2	Mercy Alliance Loans	X		Hospital Renovations	varies	2003	5,570,000	5,570,000	2018	6.1360	173,887	2
3	Capital Leases	X		Hospital Equipment	various	various	872,000	391,974	various	various	44,957	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 8,192,000	$ 7,391,974			$ 231,946	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 8,192,000	$ 7,391,974			$ 231,946	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ **not broken out** Line # **26**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 1/1/2004 **Ending:** 6/30/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1999	8
	2000	9
	2001	10
	2002	11
	2003	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Harvard Memorial Hospital COUNTY McHenry

FACILITY IDPH LICENSE NUMBER 8049116

CONTACT PERSON REGARDING THIS REPORT N/A - Hospital Property is classified as not for profit - tax-exempt

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 15,202 B. General Construction Type: Exterior Brick Frame Block Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Hospital/SNF	85,800	1956	$ 3,452	1
2					2
3	TOTALS	85,800		$ 3,452	3

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	45				$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Metal Lockers			1976	771		20			771	9
10	Door Alarm System			1989	1,055		10			1,055	10
11	Wiring for Care Center phones			1990	418		10			418	11
12	Activities Office			1996	19,981	666	15	666		10,101	12
13	A/C Compressor			1996	1,922	64	15	64		1,059	13
14	Cabinets			1996	11,214	280	20	280		4,537	14
15	Wanderguard Unit			1999	2,652	133	10	133		1,303	15
16	Construct Firewall			2003	3,761	68	15	68		125	16
17	Skilled Care Nursing Station			2004	9,522	317	15	317		317	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 51,296	$ 1,528		$ 1,528	$	$ 19,686	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 53,764	$ 3,183	$ 3,183	$	10	$ 30,962	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 53,764	$ 3,183	$ 3,183	$		$ 30,962	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77	N/A									77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 108,512	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 4,711	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 4,711	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 50,648	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Building	$ 9,270,954	$ 221,363	$ 5,209,344	86
87	Equipment	4,652,352	122,732	3,492,514	87
88					88
89					89
90					90
91	TOTALS	$ 13,923,306	$ 344,095	$ 8,701,858	91

G. Construction-in-Progress

	Description	Cost	
92	N/A	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: All Rental Equipment is short term rental.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [x] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 789 Description: short term rental of pulse oximeters
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	None		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 **Report Period Beginning:** 1/1/2004 **Ending:** 6/30/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 6/30/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 829,665	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,574,095)	2,734,338		3
4	Supply Inventory (priced at)	183,527		4
5	Short-Term Investments			5
6	Prepaid Insurance	53,571		6
7	Other Prepaid Expenses	35,414		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,836,515	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	610,657		13
14	Buildings, at Historical Cost	9,325,703		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	4,706,116		16
17	Accumulated Depreciation (book methods)	(9,020,402)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP & Other Assets	816,801		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 6,438,875	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 10,275,390	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 355,874	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,005,846		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,299		32
33	Accrued Interest Payable	420,240		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Current Liabilities	3,503,365		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,306,624	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	7,391,974		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 7,391,974	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 12,698,598	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,423,208)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 10,275,390	$	48

***(See instructions.)**

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (475,529)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (475,529)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,947,679)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,947,679)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,423,208)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,230,918	1
2	Discounts and Allowances for all Levels	(4,361,334)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,869,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	26,812	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	31,221	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 58,033	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,774	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,774	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain on Sale of Asset	949	28
28a	Misc Non-operating Income	51,627	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 52,576	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,981,967	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	840,342	31
32	Health Care	5,038,673	32
33	General Administration	1,823,310	33
	B. Capital Expense		
34	Ownership	602,314	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	12,353	36
	D. Other Expenses (specify):		
37	Bad Debt	612,654	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,929,646	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,947,679)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,947,679)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,040	1,328	$ 53,125	$ 40.00	1
2	Assistant Director of Nursing					2
3	Registered Nurses	15,685	16,844	434,349	25.79	3
4	Licensed Practical Nurses	31	33	476	14.42	4
5	Nurse Aides & Orderlies	14,202	14,414	188,203	13.06	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,675	7,973	143,665	18.02	7
8	Rehab/Therapy Aides	3,670	4,145	71,299	17.20	8
9	Activity Director					9
10	Activity Assistants	2,109	2,338	27,321	11.69	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor	1,072	1,300	26,062	20.05	13
14	Head Cook	3,143	3,451	30,775	8.92	14
15	Cook Helpers/Assistants	7,337	7,914	53,250	6.73	15
16	Dishwashers					16
17	Maintenance Workers	7,540	8,746	101,785	11.64	17
18	Housekeepers	8,792	8,912	90,118	10.11	18
19	Laundry	777	843	6,609	7.84	19
20	Administrator					20
21	Assistant Administrator	1,153	1,239	21,184	17.10	21
22	Other Administrative	2,080	2,346	46,760	19.93	22
23	Office Manager					23
24	Clerical	14,643	17,350	202,924	11.70	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	8,074	8,947	162,819	18.20	31
32	Other Health Care(specify)					32
33	Other(specify) Non SNF areas	67,529	70,384	1,778,552	25.27	33
34	TOTAL (lines 1 - 33)	166,552	178,507	$ 3,439,276 *	$ 19.27	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	225	$ 5,804	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	225	$ 5,804		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
clerical staff	clerk	0	$ 17,765
Note: all administrative salaries are allocated from			
Mercy thru interdept JE's - appears on Line 17, col 3			
under expenses			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 17,765

B. Administrative - Other

Description	Amount
Administrative Salaries from parent	$ 87,000
Dues & Publications	10,864
Misc Processing Fees	4,257
Other	2,950
TOTAL (agree to Schedule V, line 17, col. 3)	$ 105,071
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Zukowski, Rogers & Flood	legal fees	$ 838
Virchow Krause	audit fees	4,000
WIPFLI	cost report prep	1,200
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 6,038

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,229
Unemployment Compensation Insurance	20,253
FICA Taxes	238,811
Employee Health Insurance	356,158
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Life & Disability Insurance	16,819
Pension	154,413
Employee Physicals	4,315
Employee Appreciation	6,444
Employer TDA Match	26,396
Accrued Paid Leave	28,308
Allocated to non-SNF areas	(805,537)
TOTAL (agree to Schedule V, line 22, col.8)	$ 117,609

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Professional Membership Dues	11,057
Publication Subscriptions	2,509
Misc, Promotional Functions	2,803
Allocated to non SNF areas	(7,999)
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,370

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 0
In-State Travel	2,853
Seminar Expense	1,784
Allocated to non SNF areas	(2,266)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,371

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Harvard Memorial Hospital # 8049116 Report Period Beginning: 1/1/2004 Ending: 6/30/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Harvard Memorial Hospital **#** 8049116 **Report Period Beginning:** 1/1/2004 **Ending:** 6/30/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. **no**

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **not available** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **12,353**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **none** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **26,564**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **WIPFLI** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.